



# MISSION CONNECT--ROMANIA

JERRY AND MARY SWEITZER

P.O. BOX 3628 PEACHTREE CITY, GA 30269

PH: (770) 461-4778 Cell: (502) 633-8171

E-mail: [jsweitzer@missionconnect.net](mailto:jsweitzer@missionconnect.net) / [msweitzer@missionconnect.net](mailto:msweitzer@missionconnect.net)

Web: [www.missionconnect.net](http://www.missionconnect.net)

## APPLICATION FOR SHORT-TERM MISSION TRIPS

Please fill out this form in its entirety, and mail it in with a \$100.00 non-refundable deposit. The deposit will be applied to the cost of the trip.

### PERSONAL DATA (Please print or type)

Legal Name: Last \_\_\_\_\_ Middle \_\_\_\_\_ First \_\_\_\_\_

Address: Street: (As it appears on your passport.)  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_ Email address: \_\_\_\_\_  
\_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

\_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\_\_\_\_\_ Number of Children \_\_\_\_\_ Do you attend church \_\_\_\_\_

Occupation: (Describe your present employment and any pertinent information regarding work experience as related to missions.)  
\_\_\_\_\_

Language: Are you fluent in any language other than English? \_\_\_\_\_ Language \_\_\_\_\_ Ministry \_\_\_\_\_

Experience: (List any ministry in which you may have participated and tell what your role in that ministry is/was.)  
\_\_\_\_\_

Do you have any medical problems that would limit or restrict your participation in a mission trip? If yes, please explain.

## **PERSONALITY PROFILE:**

- 1. What would you say are your top three spiritual gifts?**
- 2. Describe your personal STRENGTHS:**
- 3. Describe how OTHERS view your personality:**
- 4. What would you say are your personal weaknesses?**
- 5. When did you become a Christian?**
- 6. How would you describe your relationship with Jesus Christ?**
- 7. Why would you like to participate in this trip?**
- 8. What do you hope to learn from a mission trip like this?**

**MEDICAL INFORMATION AND RELEASE**

(This form is private, but must be filled out in order to participate with Mission Connect) NAME:

\_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_ MEDICAL INSURANCE

PROVIDER: \_\_\_\_\_ ID#

\_\_\_\_\_ GROUP# \_\_\_\_\_ NAME

OF PRIMARY PHYSICIAN: \_\_\_\_\_ ADDRESS:

\_\_\_\_\_ CITY:

\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: ( )

\_\_\_\_\_ EMERGENCY CONTACT PERSON:

\_\_\_\_\_ RELATIONSHIP:

\_\_\_\_\_ Phone: ( ) \_\_\_\_\_ CITY:

\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP \_\_\_\_\_ PHYSICAL

LIMITATIONS: ( Please list)

LIST ANY MEDICAL OR FOOD ALLERGIES:

BLOOD TYPE: ANY SURGERIES THE PAST THREE YEARS? (LIST)

*In an emergency, I give my permission to a licensed physician to care for me in the way he/she deems best for my medical condition. I understand that every effort will be made to inform my emergency contact before any actions are taken.*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_